network
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Times are a changing: what does the new Drug Strategy mean for primary care?

The changes brought in by the coalition government are so numerous that it is difficult to keep apace with what is happening, how everything will fit together, and how it will affect drug and alcohol services in the future. In this edition of Network we will look at some of the main themes of the new political environment and how they may impact on primary care based drug treatment. Much still remains unclear but we will try to guide you through the challenges and opportunities the moving landscape will bring. The Drug Strategy is out and we include a range of views on that: **Paul Hayes**, National Treatment Agency gives his thoughts on page 6 and **Peter McDermott**, Policy Officer, The Alliance reflects on the document on page 7.

In the early days of the government, news of changes to the field were based on speculative press reports; against the already worrying backdrop of drastic spending cuts came talk of time-limited methadone, abstinence as the only treatment option, and an end to welfare for drug users who refuse treatment. We don't know whether it was through the consultation process or as a result of back room discussions, but most of these non-evidence based interventions did not make it into the final document. Though references to harm reduction are greatly reduced in comparison to previous strategies, it remains within the 2010 Drug Strategy, with recognition that needle exchange reduces harm, and prevention in drug related deaths, and blood-borne viruses appearing as key outcomes for services. The concept of time-limited methadone is nowhere to be seen and 'medically-assisted recovery' (MAR) is recognised, and so to SMMGP's great relief the evidence base has not been ignored at the cost of politically motivated policy. In this edition of Network, **Peter Simonson** gives his own personal account of MAR on page 3 and **Judith Yates** discusses the importance of the evidence base in her article on opioid substitution therapy on page 10. We are also excited to publish the executive summary of the updated **Royal College**

...continued overleaf

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We hope you enjoy this edition.

Editor

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of General Practitioners Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care which incorporates the previous buprenorphine and methadone guidance, as well as other alternatives, on page 8.

The new Drug Strategy describes *recovery* as a journey defined by the individual, and not as an end state, and calls for all services to be focused on encouraging recovery throughout the treatment process. With our links into community services, and our ongoing relationships with drug and alcohol users and their families, primary care is in a great position to support this aim. **Ollie Batchelor** gives examples of how services can focus on recovery in his article about the *Recovery Rocks* choir on page 12.

We believe some of the essential elements of the Drug Strategy's aspirations for supporting recovery, including an emphasis on stable housing and employment are going to be severely challenged with the cuts to services that will be an inevitable consequence of the Spending Review. And as **Elsa Browne** discusses in her article on stigma on page 4 we need to ensure there are no barriers to treatment at our surgery doors.

There is more to be tentatively pleased about. There is inclusion of the problems of over-the-counter medications and abuse of prescribed medications, including benzodiazepines, which can only be good news. The 2010 Drug Strategy also ends the increasingly discordant practice of having separate national strategies and funding streams for drugs and alcohol, and prison and community services. The funding for drugs and alcohol (for severely dependent drinkers) will lie with local Directors of Public Health (employed by local authorities) who will be responsible to the new Public Health England (PHE) service. Public health seems like a good place for drug and alcohol work to be, focusing on prevention as well as treatment. What is unclear is whether the money will remain ring fenced, or how GP commissioning groups will work with and influence public health commissioning.

Payment by results (PBR) is part of the new era, and as we go to print the process of identifying drug partnership pilot sites is taking place, focusing on the following four outcomes; *free from drugs of dependence, offending, employment,* and *health and well-being.* They will run over a 2 year period, with the results being available in 2014. The idea of money following success is not necessarily a bad one, but we will watch with interest how success is to be defined. For more on payment by results, see Linda Harris's article on our website www.smmgp.org.uk. DrugScope have also provided very useful briefing on their website www.drugscope.org.uk.

The coalition's policies are likely to reduce central bureaucracy, evidenced by the streamlining of the National Treatment Agency (NTA) into the new PHE. SMMGP would welcome an end to the increasing burden of paperwork and what seems at times like incomprehensible target setting and monitoring. However, we are aware of the strong advocacy the NTA have provided for the drug treatment system, perhaps never stronger than in recent months. And with a decrease in bureaucracy, the emphasis will fall more than ever on local practitioners and service users to advocate for drug and alcohol services. If local partnerships see drug and alcohol treatment as a low priority, previously ring fenced resources may be vulnerable to being used for other services, leading to what some fear will be a postcode lottery.

Localism takes on a new meaning with the coalition government. The idea is simple: decisions will continue to be made locally, but with an end to target driven central government interference. How it will work in reality is less clear. The call for an end to targets and a concentration on outcomes which are applicable to local areas sounds refreshing but again we need to take care that local opinions don't define these local needs; we have heard reports of some commissioners imposing time-limited methadone prescribing prior to the publication of new Drug Strategy, second guessing a non evidence based policy that did not appear. And how 'local' can you make a system if the outcomes which are paid for are defined at a national level?

As the NTA's role is merged into PHE, and decision making is increasingly handed to local areas, it has never been more important for all of us providing drug and alcohol care to our patients and working in and using drug and alcohol services, to promote their value, and to translate the Drug Strategy to meet local need. Primary care, with the increasing role we will have in commissioning, can play a powerful role in advocating for drug and alcohol services in our local areas. The stigma that people using substances experience can also be experienced by the services that are provided for them; it is important that 'localism' does not translate into 'discrimination' when it comes to deciding the future of drug and alcohol services.

Editorial

Following the change in government, the last few months have been a turbulent time for the drug and alcohol field, and the dust has by no means settled yet. In this edition of Network we will keep you up-to-date with the most recent changes to policy, and SMMGP aims to keep members up-to-date over the coming months through both our website and our policy and clinical updates. Becoming a member of SMMGP is free http://www.smmgp.org.uk/html/contact/membershipform.php so if you haven't already, why not join?

What better way to keep abreast of clinical and policy changes than to attend the 16th RCGP Working with drug and alcohol users in primary care conference in Harrogate on 12th and 13th May? Speakers include Clare Gerada, RCGP Chair, and Professor David Nutt, former Chair of the Advisory Council on the Misuse of Drugs. For more details and to apply, visit http://www.smmgp.org.uk/html/rcgpconference.php

And finally, SMMGP will be holding our 5th National Conference in Birmingham this year on October 13th, offering a chance to learn and network for those interested in delivering and developing treatment for drug and alcohol users. Watch out for details on our website www.smmgp.org.uk

Enjoy this issue!

Kate Halliday
Editor

Drug Strategy 2010: Reducing demand, restricting supply, building recovery

Reducing demand and restricting supply are themes 1 and 2 of the strategy, with *building recovery in communities* being the third and final theme.

Drugs and alcohol are to be dealt with together marking the end to separate national drug and alcohol strategies, and service funding.

There is a call for services to be tailored to new trends of drug use including legal highs and misuse of over-the-counter and prescribed medicines. This includes the recognition that heroin users are aging with fewer younger people becoming dependent on this drug, and 90% of young people presenting to services do so for problems with alcohol or cannabis.

There is a call for services to be more responsive to the needs of specific groups such as black and ethnic minorities and lesbian, gay bisexual and transgender drug and alcohol users.

Prison and community funding will come from a single point, to be provided by the Department of Health.

There are plans to evaluate options for providing alternative forms of treatment based accommodation in the community for prisoners.

Recovery is recognised as an individual journey rather than an end state. Substitute prescribing, 'medically assisted recovery' continues to have a role in drug treatment.

Local Directors of Public Health, housed within local authorities and working alongside local partnerships, to be responsible for commissioning drug and alcohol services, both in the community and in prisons. How these commissioning structures will work with GP commissioning is unclear.

Local areas to develop a 'whole systems' approach to recovery, commissioning housing, criminal justice, employment and training and social services to work with drug users to provide 'end to end' support that promotes recovery. A call for principles of recovery to be embedded in all services, and active promotion of mutual aid recovery support networks and 'recovery champions' throughout the system.

Payment by results to be piloted. A move from targets towards 'money following success'.

The new Drug Strategy describes recovery as something the individual defines, rather than an end state. *Peter Simonson* gives a personal account of medically-assisted recovery. Ed.

A prescription for recovery

Although for good academic reasons I am rather wary of the normative aspects of the term *recovery* I was pleased to see that in the new Drug Strategy the coalition government recognise that recovery is "an individual, person-centred journey" and that they'll support "medically-assisted recovery" (MAR). Although I have only recently come across the term after reading the work of William White[1], Lisa Mojer-Torres[2] and Stephen Bamber[3] amongst others, I am quite willing to put myself in the category of persons journeying along the MAR pathway. But my relationship to treatment was not always thus.

I have been taking opiates in one form or another for a number of years, and for most of that time I have been scripted and either studying at university or in work. Granted, when I first got a script back in 1993, after I'd developed a dependence on over-the-counter medications during the final year of my degree studies in London, I perhaps should have been offered a detox rather than a script, but I had just started a Master of Arts (MA) at the time and this would have unfeasible. So, I got myself on a script and started to stabilise with the notion that I'd give up at a later date, after my studies. I hadn't thought about rehab as then, and for many years after, I had the belief that only rock stars and the rich had that luxury. This was, perhaps, confirmed when I went for my first inpatient detox at High Royds Hospital, a rather elegant former pauper lunatic asylum, latterly an inpatient psychiatric unit on the outskirts of Leeds. Great as it was - as I had enjoyed reading Foucault's Madness and Civilization as part of my Cultural Studies MA – it was not so great for me personally. Unfortunately I had an adverse reaction to lofexidine and had to leave and return to my script after three days. My next attempt was a home detox with dihydrocodeine which I did for a few months, after which the addiction unit at Leeds bid me farewell and not long after that I moved back to London. However, although I wasn't then aware of the definition of addiction as a chronic relapsing condition, I found that I couldn't stop myself from traipsing around the many chemists in London purchasing anything with a codeine, morphine or opium content. I wasn't really made for the day to day use of street heroin and the culture around it, although I'd occasionally buy street methadone until I got another script sorted out, this time from the Drug Dependency Unit (DDU) in Camden. Again I found that with methadone I stabilised and got myself back to work. So what was wrong with methadone? At the time, for me, everything.

> ***"I began to slowly reject my negative self-talk about being on methadone"***

All I could see was the unwelcoming offices of the DDU based at the old Temperance Hospital on Hampstead Road with a lot of drug activity going on around it and the endless forms of control I had to submit myself to. Picking up every day, endless key worker visits, lack of spontaneity as I couldn't go away without giving my prescriber two weeks notice and, if I wanted to go abroad, having to choose a country that would let me in with methadone. It was tedious and boring. And this, I believed, was the function of treatment, to make drug taking as tedious and boring as possible so that you'd quit. But I didn't, I kept one foot in the world of the clinic and one foot in the street, topping up occasionally on street drugs. I tried quitting again at home, which worked for a while but then the same thing happened. Back on a script and working my way up the publishing sector ladder I got involved with Narcotics Anonymous (NA) despite being a committed atheist and having reservations about joining any group. I got a certain amount of support there and after five years on a script decided to go into rehab, still really being pushed along because I wanted to escape from what I

1 http://www.williamwhitepapers.com/

2 http://www.facesandvoicesofrecovery.org/pdf/torres_interview_2007.pdf

3 http://www.theartoflifeitself.org/

saw as an institutionally unhealthy clinic system which has been documented so well by William White[4] in the United States.

I got accepted at a swish residential 12 step rehab in Wiltshire, and after six weeks of not exactly buying into the methodology, came out to no aftercare, apart from the little self referring I managed to do. You can guess what's coming next: in the middle of 2008 I found myself back on a methadone script and my only plans now were to get a job and wait a while. I consequently found myself interning at DrugScope in 2009 where for the first time I came across work on MAR which I devoured like a convert. I began to slowly reject my negative self-talk about being on methadone, and as I was in a supportive environment I was able to disclose that I was on medication and found I was not treated any differently. I'm currently on what these days would be considered a 'low level optimal dose' **and quite happy with it**, so that when I do meet with my key worker once a month I usually have chat about what I've been reading lately and the current concerns in the treatment sector. I'm still with the local drug team but I'm currently looking into shared care as an option to free up more of my time.

The UK treatment system, and from my experience the mutual aid groups such as NA, are a long way from the US in accepting MAR as a treatment model for those who wish to go down that route. Medication-Assisted Recovery is a model of recovery which differs from the abstinence model in that those who are stable on a range of medications such as methadone, buprenorphine, and morphine are able to participate in the recovery movement. The UK has been rather slow in taking this idea forward whereas the US has several years of establishing this model. It works along with the usual recovery supports such as counseling and peer support. Although these medications are not a *cure* to dependency, they do help thousands maintain a fruitful and enjoyable life and play a role in helping people begin and sustain recovery. GPs may find Stephen Bamber's Infographic on Medication Assisted Recovery of use[5].

Methadone is still a highly stigmatised medication and it's going to take a lot of pushing and shoving to get the rights for those in MAR upheld. Through The Alliance[6] and other user groups you hear stories of Drug and Alcohol Action Teams invoking time-limited scripting, or removing injectables for those who need them against all the evidence to the contrary. And in the realm of employment there should be legislation to prevent discrimination against those on medications related to drug dependency or in recovery in general. I've been working on the stigma report for the UK Drug Policy Commission and it doesn't make for optimistic reading[7].

I'm currently trying my utmost to support groups working for users' rights, and I'm involved in Frontline, the Camden service users group. I did, however, find myself err quite recently. I was having a sight test at the local optician and was asked what medication, if any, I was currently taking. I thought for a millisecond or three and replied, "ah, none…". *A luta continua** as they say.

Peter Simonson

**The struggle continues*

4 White, W. (2009) Long term strategies to reduce stigma attached to addiction, treatment, and recovery within the City of Philadelphia. Philadelphia: Department of Behavioral Health and Mental Retardation Services

5 http://www.theartoflifeitself.org/resources/medication-assisted-recovery-infographic/

6 http://www.m-alliance.org.uk/index.html

7 http://www.ukdpc.org.uk/index.shtml

The damaging effects of stigma experienced by people who use drugs can be more problematic than the effect of the drugs themselves. Drug users, their families and friends are frequently marginalised and blamed by large sections of society for a range of social ills. For things to improve, stigma must be challenged at personal, cultural and structural levels. Ed.

Stigma: the final frontier?

Despite having been awaited with a certain amount of trepidation, the new Drug Strategy is more moderate than some anticipated it may be. Elsewhere in this edition Peter McDermott comments on it, and we feel it is worth noting what it *doesn't* say as much as what it does say - gone are the worrying threats of 'time-limited methadone' and forcing people into abstinence.

Rather, the Drug Strategy holds the promise of recovery for people who come into treatment for problems with their drug use. However, casting a long shadow over the aspirations it sets out for reintegration of drug users into the community is the miasmic presence of stigma.

Several articles in this Network edition – without setting out to do so – example an experience of the negative impact of stigma. Peter Simonson's article on his eventual acceptance of his recovery path as being medically assisted, and Judith Yates' description of the patient in withdrawal sitting on the wall outside her practice, allude to responses to stigma - both from the person seeking help and from others - as barriers to getting the right treatment. Just for starters, imagine how many people it prevents from seeking help and getting treatment.

How is stigma in society perpetuated? Frequently by the media - negative media reporting can entrench community resistance to helping drug users lead a fulfilling life. Sensationalist reporting can lead to a backlash against drug users, and to an increase or exacerbation of the problem if it is glorified by publicising celebrity use[1].

1 Addicted to News: A Guide to responsible reporting on opioid dependence and its treatment IHRA 2009

DrugScope have produced an excellent media guide to responsible reporting[2] which quotes a service user as saying that *'…(media reporting) alienates vulnerable people who just need help … there is never anything about how drug treatment can help turn lives around'*. Whilst it must be acknowledged that the National Treatment Agency has done a lot to publicise the benefits of drug treatment, we are puzzled to note that they have introduced terminology that refers to 'drug addicts' on their website, against the advice of other experts in the field. Terminology is difficult to get right. Although 'addict' is used extensively in 12 step programmes, this is an example of people choosing to use these terms about themselves. SMMGP disagrees with government agencies defining the whole person by only one of their behaviours – *drug abuser* or *drug misuser* is almost worse.

The UK Drug Policy Commission, which has recently been involved in a large research study related to stigma, believes that stigma is a serious hindrance to the ambition for recovery and warns in a report published during December that the government's new Drug Strategy will fail unless stigma towards people who use drugs is tackled head on, because it will prevent them from playing a more positive role in communities and reintegrating into society[3]. They call for more balanced reporting of drugs issues in the media, including stories that will help the public understand drug dependency and routes out of it.

During the course of 2010, SMMGP has participated in various projects looking at the problem of stigma and its impact on treatment outcomes, which have raised our awareness of the extent of the problem. As mentioned in our November 2010 policy update[4], when we participated in the Royal Society of the Arts (RSA) Whole Person Recovery Project, we had to face up to their findings that whilst some respondents in their survey did have a good experience when approaching their GP, others did not. As GPs are often the first port of call when someone experiences problems with drug or alcohol use, and the vast majority of people are registered with a GP, there were two main issues reported in the RSA project that those seeking help encountered when approaching their GP. The first issue is related to the small amount of under-graduate training in substance use; but the second issue is that respondents felt that GPs could be strongly influenced by the stigma associated with substance use, which created unhelpful tensions from the start[5]. We are therefore pleased to have been invited to work with the RSA on the toolkit they propose to develop for GPs in that area.

> ***"the government's new Drug Strategy will fail unless stigma towards people who use drugs is tackled head on"***

It is easy in the rarefied atmosphere that we work in, where we are constantly in contact with like-minded people to start believing that everyone thinks like we do, but another example where stigmatising had to be dealt with was recently in our office when someone phoned to cancel their practice's free subscription to Network, with the words*: "The doctor who used to treat those people has retired, and we aren't going to have those type of people here any more"*. SMMGP is sometimes challenged about what we are doing to drive up quality of treatment where it is most needed, or what are we doing to reach doctors who need to be better informed. We will therefore explore the possibility next year of getting involved in a project aimed at under-graduate medical students, with one of our partners, as a start to reaching new audiences.

The quality and range of drug treatment has improved, and availability has increased especially in general practice, from 0.5% to 32% of practices being involved in the last 15 years. But we still have much to do to improve how we treat drug users. We must continue to fight stigma against people who use drugs on personal, cultural and structural levels and continue to highlight the negative impact of stigmatisation, and challenge it wherever necessary. Areas for action include:

- We will challenge stigma in ourselves and our colleagues and acknowledge when people present for help what enormous difficulties they have faced so far
- We need to challenge existing language and negative images which reduce a person to 'the addict'
- We will continue to challenge media reporting where it is inflammatory and/or wrong and support service user and advocacy groups to do the same
- We will challenge institutional and government policy where it too adds to the stigma
- We will participate in education and information campaigns to help improve public understanding
- We will continue to contribute towards improved training for professionals who come into contact with people with addiction problems.

Countering stigma and its associated harms to the physical, social and mental health of people who use substances is consistent with harm reduction and the whole recovery agenda. The stigma that people who use drugs face every day is, we believe, the final frontier that must be challenged.

Elsa Browne, Project Manager, SMMGP

2 The media guide to drugs: key facts and figures for journalists http://www.drugscope.org.uk/resources/Media+Guide.htm

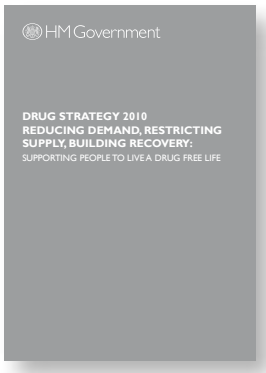
3 Getting serious about stigma: the problem with stigmatising drug users UKDPC 2010 http://www.ukdpc.org.uk/publications.shtml#Stigma_reports

4 SMMGP Policy Update November 2010

5 Whole Person Recovery: a user-centred approach to problem drug use RSA 2010 http://www.smmgp.org.uk/html/smmgpupdates/2010/policy_2010_11.php

Paul Hayes, **Chief Executive, National Treatment Agency outlines key points of the new Drug Strategy, and reflects upon the likely impact this will have on the drug and alcohol field. Ed.**

The new Drug Strategy: opportunities and challenges



The principle of integrated treatment is an emerging theme of drug policy in England. Most problematic drug users have an array of health needs alongside their dependency, so GPs have a crucial role to play in facilitating substance misuse services through shared care as part of a wider package of health care.

Ironically drug policy did not feature significantly in the general election of 2010, and was barely mentioned in the new coalition government agreement. Yet a momentous political year ended with three extremely significant developments.

First, a white paper on public health proposed that drug treatment services will in future be commissioned locally by Directors of Public Health, employed by local authorities but accountable to a new national public health service, Public Health England.

Then a new Drug Strategy proposed that within this new locally-owned landscape, treatment for drug and severe alcohol dependency would be aligned, services in prison and community would be integrated, and the system rebalanced to focus more on outcomes.

Both these policy statements, from the Department of Health and the Home Office respectively, confirmed that the key functions and staff of the National Treatment Agency (NTA) will be transferred to Public Health England in April 2012.

And from them flowed the third development, as in the interim the NTA has been mandated to lead the development of a recovery-oriented drug treatment system. Hence we launched a public consultation last month on a new national framework to replace *Models of Care*.

Change in recent months has thus gone hand in hand with continuity. This theme will continue in the coming years as there is no single point of change. The Drug Strategy is already in force, but Public Health England is over a year away and will not have its ring-fenced budget until 2013.

Meanwhile the local landscape will alter further, once the promised Police and Crime Commissioners arrive, while in 2014 we will have the results of pilot schemes for payment by results.

The NTA's role in these changing times is to manage the transition and steer drug treatment towards its new home in Public Health England.

We will therefore seek to further improve workforce capability through support for the Skills Consortium for Substance Misuse[1]. We will do more to incentivise performance, particularly successful completions – work which will complement the payment by results pilots.

We will ensure transparency and accountability through the National Drug Treatment Monitoring System and the Treatment Outcomes Profile, to measure outcomes and drive innovation. And we are further developing the evidence base through the work of Prof John Strang's expert group on prescribing practice.

The new emphasis on recovery in the Drug Strategy reflects the spirit of the times. Yet it is also consistent with the principles of the Treatment Effectiveness Strategy the NTA introduced in 2005.

We have been saying for some time that the treatment system should be more ambitious for service users. Most of them want to get better, and we need to do that as safely as we can.

> ***"The new Drug Strategy is unashamedly recovery-focused, but that does not mean it is abstinence-obsessed"***

One particular challenge is to ensure that even the most entrenched service users have this opportunity. We know it can take several years for heroin addicts to overcome their dependency, so it is hardly surprising that a large proportion of those in treatment - about 95,000 at the last count – had been on a substitute prescribing regime for longer than a year.

What is less clear is the continuing value of treatment to the 35,000 people who have been on methadone for more than four years. For some, this is a triumph because the substitute prescription enables them to hold down jobs, lead positive family lives and have a stake in society. For others, however, it may be a tragedy, because they could have been helped towards recovery sooner, leaving both addiction and treatment behind to get on with their lives.

The new Drug Strategy is unashamedly recovery-focused, but that does not mean it is abstinence-obsessed. There is no political appetite to challenge the maintenance of a balanced treatment system in which harm reduction services are the bedrock of what we do and a gateway into treatment and recovery. Our challenge for the future is adding recovery into what we do in a more systematic way, not subtracting harm reduction.

The treatment system is already more ambitious, as evidenced by the doubling of numbers successfully completing treatment free of their dependency to almost 25,000 over five years.

This momentum can only be enhanced by the Spending Review decision to bring together central funding streams under the Department of Health umbrella. I am confident that having one pot with one purpose means there will be enough money in the national kitty next year to deliver the new Drug Strategy.

However I am less sure we will be able to rely on significant sources of local funding from councils and Primary Care Trusts as in the past. I understand the financial pressures that local authorities are under, but I believe any disinvestment now would be a grave mistake, just when they are about to be handed a key role to develop and deliver local solutions to public health challenges like drug and alcohol dependency.

In these straitened financial times, the NTA is therefore pleased to be able to continue to support the SMMGP network and recognise its important role as the expert voice of the profession.

Paul Hayes, Chief Executive, National Treatment Agency

1 http://www.skillsconsortium.org.uk/

Peter McDermott, **Policy Officer The Alliance reflects upon the new Drug Strategy. Ed.**

Reflections on the new Drug Strategy

And so it's finally out.

Many of us have been dreading the 2010 Drug Strategy. Early indications suggested that we might get a strategy that was ill-informed, politically-driven and punitive. We feared the abandonment of the huge gains drug treatment has made during the last decade, and a return to the Dark Age of the early 80's, when inadequate dosing and time limits dominated the drug treatment landscape.

Sadly, not all of us were dreading this outcome. There were some services that were adopting time limits from the moment the new government took office after reading the runes in the statements of various politicians and in the National Treatment Agency's (NTA) business plan.

To their credit, the NTA has always said that they wouldn't move until they'd taken expert advice and whatever they did would be grounded in the research evidence. But a section of the British drugs field has always felt that instinct and prejudice were a better guide to practice than evidence, despite the overwhelming weight of research from around the globe demonstrating the massive efficacy of opioid substitution therapies.

So my first response on reading the new Drug Strategy was one of relief. Despite all the earlier rhetoric, it accepts the value of substitute prescribing, accepts that people can recover while on substitute medication and avoids going down the line of prescribing time limits. For the many of us who owe what hard won stability we have to substitute prescribing, it feels like we've averted a major disaster.

A second headline item in the strategy is the new emphasis on recovery, an area that's not without its own set of accompanying anxieties. You don't have to spend very long talking to service users to recognise that large sections of the drug treatment field haven't been doing enough to help people achieve their aspirations. I've spent most of the last two years helping to make the drug treatment system in Sefton more recovery-focused.

It's my view though, that recovery has to be grounded in attraction rather than compulsion. You can't 'force' somebody to undergo the kind of gestalt switch that recovery relies on – we still await the magic bullet that can shift somebody from wanting drugs so badly that they're willing to sacrifice everything they have and hold dear to them – all you can really do is create an environment that's generally supportive instead of an environment that creates obstacles to recovery.

And so much of what is in the strategy – the use of recovery champions, of treatment mentors, the creation of recovering communities, forging greater links between education, training and employment pathways – quite effectively describes our work in Sefton as one of the Systems Change Pilot programmes over the past two years. However, the new Drug Strategy ignores some key elements that we believe have been crucial to our success.

Programmes like this have to be based upon attraction rather than compulsion. Forcing people to be involved in recovery programmes inevitably brings in some who have no desire to be there, and who may subvert the programme and jeopardize the stability and wellbeing of those who are committed to change.

Then there's the lack of any indications around funding. While it isn't difficult to attract people into volunteering for this kind of programme, you can't run it for nothing. People need training. They need premises to work from. They need support and supervision.

One of my big concerns is that the mentoring initiatives appear to fall within the remit of the Department of Work and Pension (DWP). As a consequence of Iain Duncan Smith's personal interest in the recovery agenda, DWP have played an active role in shaping the drug strategy, particularly in the thinking around reintegration. That said, I'm pretty sure that none of the mentors I'm working with would have come anywhere near me if they'd known the DWP was involved, as their anxieties about potential threats to their benefits mean that they'd almost certainly give me a wide berth. Perhaps that'll change with the reorganisation of the benefits system.

It's also worth pointing out is that this stuff isn't easy. As with user involvement, anybody can set up a tokenistic programme that ticks a box. Creating programmes that support people with significant deficits in social capital while they take tentative first steps into the big world requires charisma and talent to attract and maintain individuals.

And people might be in recovery when you initially recruit them, but relapse remains the rule rather than the exception. Dealing with that, without piling additional shame and stigma on people requires a lightness of touch that's often conspicuous by its absence in our field.

The last big headline issue in the strategy is *payment by results*. This one has the capacity to impact on those who provide services as well as on those who use them. It could introduce a degree of transparency into the field, ensuring that the most effective providers will grow and expand, while those who rely solely on expertise in marketing and spin will wither on the vine.

But this too has the capacity to be damaging. How do we stop providers from cherry picking, working only with those who have the best chance of a full recovery? Those with most complex needs – the people who need most from treatment – might actually end up getting least!

The advertisements for the Payment By Results (PBR) pilots have now been published, along with interim outcomes. The current thinking is that these will be running for the next two years, and other areas will adopt those aspects of PBR commissioning as the strengths of the new system become apparent. Nevertheless, despite this shift from a model of compulsion, to a model of attraction, the model of funding appears to be based upon rewarding those services that successfully achieve sustained recovery – which may be problematic when dealing with a condition that is characterised by its chronic and relapsing nature.

More worrying, perhaps, is that there appear to be no plans to assess the impact that these changes will have on our drug treatment system. If these changes actually make the system worse, will we have any way of knowing that? Will there be a way to reverse those changes? Are we really that confident that these changes won't have any unintended consequences, and their impact will be overwhelmingly positive?

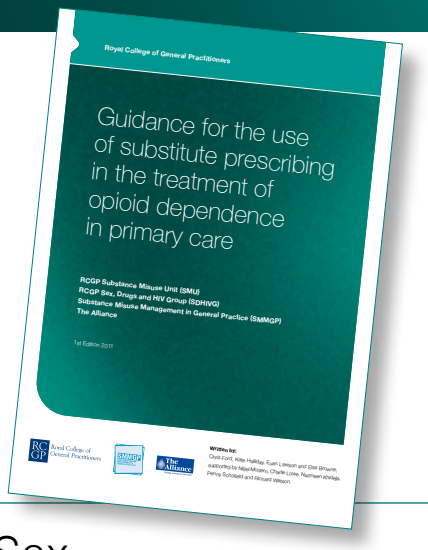
And hasn't much of the criticism of the last few drugs strategies been aimed at precisely this issue? It does seem peculiar to implement a series of significant changes to any system, without having a way to assess the impact of those changes and a way to correct them if the outcomes turn out to be worse, rather than better.

Peter McDermott, Policy Lead The Alliance

We are pleased to give a special preview of the executive summary of the updated Royal College of General Practitioners opioid guidance. Ed.

Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care:

Executive summary



RCGP Substance Misuse Unit (SMU), RCGP Sex, Drugs and HIV Group (SDHIVG), Substance Misuse Management in General Practice (SMMGP), The Alliance

Opioid dependence is common in the UK and there are effective substitution medications, including methadone and buprenorphine, to support treatment. This guidance covers the use of substitute medication, which can be an important element in the treatment of opioid dependent patients and their medically assisted recovery.

Effectiveness

- Methadone and buprenorphine are effective evidence-based medications used in the treatment of opioid dependence.
- Both are effective support agents in detoxification.
- The primary function is to reduce (and eventually replace) illicit opioid use and in so doing reduce harm and improve the health and psychological well-being of the patient.
- Both are more effective as part of a package of care that includes psychosocial support.
- There are other drugs, such as morphine sulphate, dihydrocodeine and diamorphine, which are also occasionally used and which have an increasing evidence base, especially world-wide.

Maintenance or detoxification

- Choosing between maintenance and detoxification regimes can and should occur at many points during treatment, starting at the first assessment and then at various points, as appropriate.
- Methadone and buprenorphine can be used as maintenance interventions or as detoxification agents. Other medications, such as long-acting morphine sulphate, and dihydrocodeine, can also sometimes be used.

Maintenance

- Methadone is still considered the gold standard substitute medication for long-term opioid dependence. However, buprenorphine is also effective.
- Optimal daily dose for maintenance is usually between 60 and 120mg for methadone and 12 and 32mg for buprenorphine. Some people need larger doses, and some smaller.
- Methadone is usually prescribed in an oral liquid formulation 1mg/ml. Buprenorphine is prescribed as sublingual tablets of 0.4mg, 2mg or 8mg; or in a buprenorphine/ naloxone combination as 2mg/0.5mg and 8mg/2mg tablets.

Assessment

- Before prescribing any substitute medication opioid dependence should first be confirmed by history and examination, including physical examination, and by toxicology screening using urine or oral fluid swabs.

Induction

- The initiation of methadone and buprenorphine are very different.
- *For methadone:*
  - Start low and titrate up slowly until optimal dose to prevent the risk of overdose.
  - The starting dose of methadone should be low: between 10mg and 30mg daily, depending on the amount of heroin, the length and method of use or other opioids being used, because of the cumulative effect until steady state is reached.

- Methadone doses should then be titrated upwards to optimal levels, usually between 60 and 120mg.
- Methadone increases of between 5 and 10mg a day, with a maximum of 30mg dose increase each week for the first 2 weeks, are recommended. (After that the rate of increase can be slightly quicker.) In those with short history, young people or unknown tolerance, increases may be slower.

- *For buprenorphine:*
  - Need to get the time of the first dose of buprenorphine right after use of heroin (or methadone or other opioid) to avoid precipitated withdrawal then can increase dose quickly
  - Start at least 8–12 hours post heroin or 24–36 hours post methadone and when withdrawals have begun, to avoid precipitated withdrawal.
  - Precipitated withdrawal only occurs on the first dose; the longer this first dose can be left post heroin or methadone use, the lower this risk.
  - Doses above 12mg (16mg more effective) block the effect of heroin and other opiates if used on top.

- Doses should be supervised through induction and until stability is achieved.

- Three months is advised as the length of supervision but this can be shortened if it is clinically unnecessary or a hindrance to the patient, e.g. due to employment.

- Both should be prescribed in instalments, on FP10 (MDA) in England and Wales or GP10 (3) in Scotland, initially daily.

- It is the responsibility of the prescriber to ensure safe induction on to these drugs. This responsibility cannot be delegated. However, a close working relationship with pharmacists and drug workers can be helpful in facilitating titration to an adequate dose as quickly as possible.

Stabilisation

- Stabilisation involves finding a suitable dose that keeps the patient engaged in treatment without the need to supplement with other drugs and/or heroin.

- The process of psychosocial support is often strengthened once drug use has been stabilised.

Interactions

- Both methadone and buprenorphine interact, although more so methadone, with other central nervous system (CNS) depressants, including benzodiazepines, antidepressants and alcohol, increasing sedation and hence the risk of overdose; patients must be informed of this.

- It is important to remember that several missed doses may mean a loss of tolerance to opioids.

- Three days missed consecutively should lead to a dose review and possible reduction in dose.

- Five days or more missed consecutively should lead to re-assessment and re-induction if there is likely to be significant loss of tolerance.

- Effective opioid maintenance doses enable patients to remain tolerant to opioids and thereby provide important protection against overdose. Opioid users in effective treatment are far less likely to overdose than those not in treatment.

Ongoing care

- Treatment is reviewed at every contact and needs to be re-examined more formally, about every 3–4 months, to measure improvements in health and well-being, and to monitor any use of alcohol or drugs on top of the prescribing.

- A prescriber should also review the prescribing and the other elements of treatment as part of an overall package of care to support people on their road to recovery.

- A toxicology screen (urine or oral fluid swab) needs to be taken frequently at the beginning of treatment and when the patient is stabilised regularly (usually between two and four times a year) if continuing on maintenance, to confirm use of medication and to monitor use of additional drugs.

- Screens should never be used punitively, but as an aid to treatment.

- Screens positive for heroin, or other drugs, require a review of treatment and dose, but should not normally lead to the cessation of treatment or dose reduction.

- It is important that patients are given good information on the drugs they are being prescribed, and on their actions and effects, along with advice on safe storage of take-home doses.

Special groups

- It is important to remember the needs of special groups, such as black and minority ethnic (BME) communities, polydrug users, people with dual diagnosis, problematic drug users in prison or hospital, and women who are pregnant and / or have children.

Primary care-based drug treatment

- Treatment of people who use drugs is multifaceted and the patient should always be at the centre.

- Managing their care normally requires a multidisciplinary response; wherever possible, this should be provided in collaboration with others such as other primary care practitioners, practice nurses, dispensing pharmacists, practitioners with a special interest and addiction specialists.

- Practitioners should only prescribe and treat to the level of practice at which they feel competent and confident.

- Stable patients may not need as much input as those new to treatment but they must always continue to be reviewed and supported to make changes at each appointment with a major review at least every 3 months.

Copies of the full guidance will be available on line in the next few weeks at **www.smmgp.org.uk**

Judith Yates **looks back over her 30 year career as a GP and how her experience of working with drug users has echoed what the evidence tells us about good practice. Ed.**

Evidence based practice: opiate substitution therapy

As a young GP in the late1970s, I was learning dangerously from day to day. The local drug users were the experts in this field and were my main source of information about opiate substitution therapy. This was after manned space flight, but long before the internet and the 'Orange Book' Guidelines[1].

I first met Tony when he was seventeen. In the 1980s, when the heroin epidemic was flooding through Birmingham, he enriched my understanding of the drug world, offering Blue Peter type demonstrations on how to make crack pipes from Pepsi cans and inhalers. Long before I had heard of Clinical Opiate Withdrawal Scale scores, he showed me the misery of the early morning opiate withdrawal syndrome, sitting shivering on the low wall outside my surgery at dawn.

Expert opinion (perhaps especially that of a drug user) comes very low down in the pyramid of evidence which puts Cochrane type meta-analysis at the top, but in the days before the Orange Book gave government support to building research consensus, Tony showed me that high dose methadone prescribed predictably and steadily eventually allowed him to cope with life and gradually gain the physical, psychological and social strength to begin to plan and build a life away from the drug world.

We met every couple of weeks for twenty-three years. The first three planned residential detoxes were followed swiftly by relapse, and a quick return to prescribed methadone. On the fourth occasion he at last escaped his dependency and has not looked back. Six years later he is still living a drug and alcohol free life and has been in full time employment for the last three years.

It is eighty-four years since the Rolleston Inquiry [2] recommended government endorsed guidelines to prescribe opiates not only to *treat* addiction, but also to *maintain* those who, like Tony, could live useful lives with the drugs but not without. We have been re-inventing this particular wheel ever since.

Research confirms that Tony's opiate using career with its twists and turns, and life threatening complications, was longer than average but not unusual. Best and Day[3] published analysis of interviews with 107 UK abstinent drug users (Tony was among them). The group had lived successfully opiate free lives for an average ten years. Their drug using careers had averaged ten years, and an average of three detox attempts were needed before their eventual established abstinence.

This confirmed the more historical findings of Simpson and Sells[4] working in Texas, who reported twelve year follow up of 700 people treated between 1969 and 1972, and also found average heroin using careers to be almost ten years. Of this group, 55% were not using opiates at all after twelve years.

Given this background, it felt very strange to read in the summer the suggestion that the principle of strict time limits might be extended from prisons to community settings in the draft National Treatment Agency Business Plan 2010-11 [5]. Thank goodness not everyone shares Mrs Thatcher's dislike of U turns, and in December I was delighted to see that this suggestion was removed from the final Drug Strategy, following sensible representations that there is no evidence to support the suggestion that time-limited treatment is either safe or effective[6].

On the contrary, there is compelling evidence that inflexible treatment packages[7] of which time–limited treatment must surely be an example, result in people dropping out of treatment with all the associated risks, in particular, that of drug related death, which is twenty times higher than for those who stay in treatment involving prescribed opioids[8].

I recently signed the Vienna Declaration[9], which calls for international incorporation of scientific evidence into drug policy. As GPs we become experienced at evaluating peer-reviewed research and government endorsed guidelines to identify best practice for the particular circumstance of the patient in front of us. For opiate dependency, the recovery process may involve a long and circuitous journey, and primary care teams are well placed to help people find a more positive place in their family and the community.

> ***"For opiate dependency, the recovery process may involve a long and circuitous journey, and primary care teams are well placed to help people find a more positive place in their family and the community"***

In my clinic last week I saw three people in quick succession who demonstrate that in drug treatment individual focused therapeutic plans are needed, that imposed time-limited treatments have no place, and that recovery starts from the first appointment, and lasts sometimes weeks and sometimes years.

- A twenty-one-year-old girl has transferred from another area. She has been using since she was first given crack and heroin by and older male "friend" when she was living in care at the age of twelve. She gave me some clues about the abuse she had suffered in infancy, and I expect that she will need considerable support and probably opiate substitute therapy for several years.
- A thirty-six-year old man was brought along by his wife. He had been opiate free, but a credit crunch redundancy had led to time spent in the bookmakers, where the smell of heroin from the back room eventually proved a trigger to relapse. His wife recognised the signs of his early morning rattle immediately, and with her support I think he will succeed in his requested quick stabilisation and community detox.

1 Department of Health (1999). Drug misuse and dependence: guidelines on clinical management. London: Department of Health.

2 The Rolleston Legacy . Drug and Alcohol Findings (2006)

http://findings.org.uk/docs/Ashton_M_28.pdf

3 Best, D et al (2008) *Breaking the habit: a retrospective analysis of desistance factors among formerly problematic heroin users* Drug and Alcohol Review 27(6): 619-624

4 Simpson, D. D., & Sells, S. B. (Eds.). (1990). *Opioid addiction and treatment: A 12-year follow-up*. Malabar, FL: Krieger Publishing Co.

5 Brindle, D (2010) Limits to methadone prescription proposed by drug agency The Guardian 18th July 2010

6 Drug Strategy (2010)

Reducing Demand, Restricting Supply, Building Recovery :Supporting People to Live a Drug Free Life

http://www.homeoffice.gov.uk/publications/drugs/drug-strategy/drug-strategy-2010?view=Binary

7 National Treatment Agency for Substance Misuse (2009) *Towards successful treatment completion- a good practice guide*. London, NTA.

8 Fugelstad A et al (2007) *Methadone maintenance treatment: the balance between life-saving treatment and fatal poisonings*. Addiction 102 (3) ; 406-412.

9 Vienna Declaration

http://www.viennadeclaration.com/

- The third man I have known for many years. He lives alone, with his irritable dog, has survived a lot of ill health, and has lightened my life with Christmas cracker type jokes, until now distracting me effectively from any suggestion of detox. (Example: "what do you call a chicken in a shell suit?" Answer "an egg"). He astonished me this week by saying "you can cut that methadone dose down by 10mgs doc, I've been taking less".

We all know that methadone or buprenorphine prescriptions on their own are not enough but for many, without them the journey cannot even begin. I had a card from a drug free patient last week, which said "thank you for your patience and enthusiasm for me to succeed". Patience and enthusiasm are certainly useful and I am only too delighted to stop prescribing as soon as possible, but I am glad we do not have to find a new space in the GPs' toolkit, for politically imposed time-limited treatments. Opiate substitute treatment should end at the point in the patient's journey which the patient and the prescriber judge to be clinically (not politically or morally) safe and appropriate.

Judith Yates
GP with a Special Interest in Substance Use

Is gambling the poor relation of addiction services? *Henrietta Bowden-Jones* describes how she went about setting up an NHS clinic for problem gamblers. Ed.

The National Problem Gambling Clinic: pioneers in the NHS

The first National Health Service (NHS) clinic specifically designated to treat pathological gamblers opened its doors to patients in 2008 having been set up by myself within the Addictions Directorate of Central North West London NHS Foundation Trust. Until then, I had been working as an addictions psychiatrist with homeless drug users in London and running an inpatient detox unit.

The vision for the gambling clinic began several years earlier in my doctorate work when I was researching the effects of ventro-medial prefrontal cortex impairment (a specific form of brain damage) on the ability of alcohol dependent subjects to do well in treatment. Some of the psychometric tests I used asked subjects to work out odds when faced with different probabilities (tests such as the Cambridge Gambling Task and the Iowa Gambling Task) identified a sub-group of subjects who were making very disadvantageous choices driven by short term gains.

As problem gambling became a topic of interest to me, I quickly realised that there was no adequate NHS provision to treat this illness in an evidence based manner. At that time, in 2007, the media was directing much attention to the government's plans of opening several new casinos and a super casino. My role as spokesperson on pathological gambling for the Royal College of Psychiatrists allowed me the opportunity of expressing publicly what I felt to be a clear gap in provision of statutory services in the UK.

Soon after that, I was able to secure the funding from the Responsibility in Gambling Trust for a pilot to treat people and to assess the need for such a service. According to the 2007 British Prevalence survey[1] the country's prevalence of problem gambling in the general population is 0.6% which equates to roughly 300,000 problem gamblers. The biggest surprise was that having set up the clinic expecting to see relatively low numbers of pathological gamblers, we were inundated, and in two and a half years we have received 700 referrals. In the beginning I was personally assessing each case but one year into this venture we had to change many of the things we were doing to accommodate demand without running lengthy waiting lists.

We offer cognitive behavioural therapy based treatment which has moved from being one-to-one to group based as the outcomes showed similar efficacy. Assessments are now done by any member of the multidisciplinary team, comprising myself as the medical director of the clinic and a team of psychologists of different grades including several trainees. We have a family therapist and a carers' worker who holds a group called Relative Connections once a week. We also have a government funded money-management training scheme within the clinic that all patients attend. Aftercare consists of weekly relapse prevention groups, as well as attendance at a life-skills charity which provides ongoing support, education and professional training to our discharged patients for a period of up to five years. This is a great support as many pathological gamblers have isolated themselves from family and friends.

Treatment at the clinic can last up to six months and drop out rates are low. We have received funding from Imperial College for the setting up of the first patient database for problem gamblers and are collecting data for each patient which will be extremely useful when we begin to correlate outcomes with individual patient characteristics. We have adapted the Treatment Outcome Profile into a tool for assessing outcomes in problem gamblers and our patients are followed up every three months.

I have also recently set up the UK Problem Gambling Research Consortium; attached to the clinic, it consists of twelve researchers collaborating with us on different projects. The research focuses mainly on the cognitive neuroscience aspects of problem gambling, as this is my main interest in the field but we will be conducting treatment trials and pharmacological trials on our patients too, at a later date. Our outcome figures look extremely promising; we will be writing them up in the near future and have already presented them at international conferences in the recent past.

I have two aims for next year. The first is to support and encourage the fundraising activity we have begun, as we have set up a charitable fund both for the clinical and the research side of the clinic's work. The second is to create closer links with general practitioners throughout the country; some are already working closely with us and refer regularly but others do not know of our existence.

We have just had the first annual conference (Problem Gambling: The Hidden Addiction) organised by the clinic at the Royal Society of Medicine which attracted one-hundred-and-twenty delegates, all wanting to learn more about problem gambling. The event was a great success and we will be holding another one next year. I hope reading this article will make you want to learn more about pathological gambling as an addiction, its consequences on the individual and his or her family and ways in which it can be treated. Finally, if you would like to know more about our clinic, or have some good ideas for fundraising work, do email me on h.bowdenjones02@imperial.ac.uk

Henrietta Bowden-Jones MRCPsych, BA (Hons), DOccMed, MD (Imperial).
Director, National Problem Gambling Clinic

1 http://www.esds.ac.uk/findingData/snDescription.asp?sn=5836

Ollie Bachelor **tells the story of Recovery Rocks, a choir that offers more than good melodies. Ed.**

Singing a new song

There are a number of characteristics of people involved in recovery orientated treatment (though not exclusive to them of course!). These characteristics are often evident in people who are clean and sober and in an abstinence based programme of recovery.

The first characteristic is generosity. This has been very evident in The Cyrenians journey to embrace and embed recovery principles in all aspects of its work over the last five years. The support of a group of individuals with decades of recovery under their belts, encouragement from staff in recovery, and advice from organisations with a long history of abstinence based work have all helped to improve Cyrenian's addiction, housing and employment services: Action on Addiction helped us to set up a 12 step-abstinence day programme in Gateshead based on their SHARP programme in Liverpool; Acorn in Manchester advised us on housing options; and OASAS in New York State and the Connecticut Community for Addiction Recovery (CCAR) remain incredibly generous advisers and friends as we plan our own Recovery Centre in Newcastle upon Tyne. CCAR's knowledge is helping our employment and housing projects in the North East of England to become as fully recovery orientated as those in Connecticut. The Cyrenians in turn is now sharing its knowledge and experience of recovery with other organisations who are wanting to change.

Another noticeable hallmark of recovery is celebration. The joy, delight and happiness that come from the achievements of individuals in recovery are really clear and are a characteristic of individuals in recovery and recovery orientated organisations. At the Recovery Walk in Glasgow, this sense of celebration was evident in the speakers and musicians and in the conversations that took place throughout the day between people from across the UK. Unity comes from being on a shared journey; overcoming a serious, life threatening health problem, overcoming the prejudices of a society still steeped in the notions of addicts as being undeserving, and overcoming a treatment system that writes people off or gives them limited hope and low aspiration is worthy of celebration.

Celebration is part and parcel of the routine at Oaktrees, the Cyrenians abstinence-based day treatment centre. We celebrate milestones of recovery such as graduations, birthdays, exit from treatment, success in training and education, employment, family reconciliation and new housing. The joy on these occasions is genuine, because the people sharing the celebrations – clients, families and staff alike, understand the significance and magnitude of the achievements. People in recovery are *over comers* and are right to celebrate what they have achieved. In the US, where addiction can seem far less stigmatised, there is a recognition of this *overcoming* that receives respect and admiration in the way that surviving cancer does.

One specific way in which Oaktrees clients and graduates celebrate is through singing. The SHARP programme in Liverpool ends the week of treatment with clients singing a popular song together. We found it both moving and enjoyable when we watched singing on a visit to another organisation, so we incorporated it into the Oaktrees programme. It has worked well. Even the most reluctant participants began to enjoy it, and the most enthusiastic decided to start their own singing group. The Sage, Gateshead, an international music venue, provided a music teacher to lead the singing and *Recovery Rocks* was formed a year ago. There is no audition to join, no requirement to be a gifted singer, no distinction between staff, graduates or those currently in treatment; the group sings together because singing is enjoyable and a unifying experience. It also builds confidence.

Songs are a good way of expressing life experiences, and many pop songs reflect aspects of the journey that is recovery. It was never our intention to perform but people became curious and wanted to hear the choir, which has now done several concerts including one at The Sage and recently at the SMMGP conference in the Newcastle Assembly Rooms. Singing in public has allowed the group to intersperse the songs with personal stories, which has proved to be a powerful way of sharing the message of recovery to those on the outside. It is not about winning the X Factor, but it is a powerful, emotional experience which carries a lot more punch than a power-point presentation. Songs that Recovery Rocks have covered include "I Can See Clearly Now", "You Can Get it if you Really Want", "Stand by Me", "Don't Look Back in Anger", "Lean on Me" and what has become the choir's favourite, a revised version of "I've Got Life". Singing is not the new therapy but it is joyful, fun and liberating whilst giving a real sense of belonging. It promotes the personal, social and community aspects of recovery capital.

Other characteristics observed within recovery communities are gratitude and humility. Whilst these may originate from the spiritual programmes in which many individuals are engaged, irrespective of their source, they are an attractive and welcome part of the movement. Gratitude certainly feeds the generous principles of sharing and giving already mentioned; it encourages a helping, supporting attitude that seems to go against the spirit of our age, which can be individualistic and self-absorbed. Most Cyrenian's clients in recovery offer support to those further back on the recovery tracks or get involved in a range of volunteering activities. They do so out of gratitude and a desire to give something back to a society that they have taken from at the height of their addiction. Their qualities and gifts are such that communities can only be enriched and improved through this participation. They are a great example of Big Society. In David Cameron's words "We need to create communities with oomph – communities who are in charge of their own destiny, who feel that if they club together and get involved they can shape the world around them". Recovery communities are exactly that.

Humility too is a quality that is evident amongst those in recovery which more organisations and staff within the treatment system could usefully display. Humility leads to greater respect for clients, a diminishing of the notion of "expert" telling people what is best for them without considering their preferences or concerns. Above all it means that workers recognise the need to work in partnership with their clients.

It is not just those in recovery who are on a journey. Grasping what recovery is about and adapting existing styles of work is proving to be a journey of hearts and minds for organisations and their staff engaged in drug and alcohol treatment. The recovery agenda is here to stay and hopefully those services which have not begun this journey will soon take the first steps on the road, embracing the generosity, celebration, gratitude and humility shown by those involved in the recovery movement so far. When we get it right, recovery really does rock!

Ollie Batchelor, Executive Director, Cyrenians

Joss Bray **is Dr Fixit to a GP who wants advice on detoxification. Ed.**

Dr Fixit on Detox

Dear Dr Fixit

I am a GP and have been working with our local drug team for three years, prescribing for stable patients who use drugs. I feel really familiar with methadone and buprenorphine but I am less confident about detoxification regimes and wonder if you could help?

Last week John, who is thirty-two years old, came to see me. He had been on 120mg methadone maintenance for two years and had done well. He has stopped using all other opioids, he still uses crack, though never more than once a week and he occasionally uses diazepam. When he first came into treatment he was drinking about fifty units of alcohol a week, often in binges but with help he has stopped his alcohol use and he attends an alcohol free group.

He is about to complete a probation order and is volunteering at the local animal sanctuary. He has decided that he wants to train in this area of work but is keen to stop his methadone prescription before he starts his studies.

He has been in rehabilitation twice before and has also done two community detoxes and an inpatient detox. The last two years have been his most stable for fifteen years.

I almost want to persuade him to stay on methadone maintenance and have discussed the evidence with him, and he remains keen to detox so we have agreed to start planning this course of action. He would prefer to do a community detox but is willing to look at all the options. Can you advise me of his options and what else I can do to support him?

Answer provided byJoss Bray, Medical Director, The Huntercombe Centre, Sunderland

In terms of evidence, we know how opiate maintenance can help people in many ways but we don't want people to be forced into this when a completely drug free life may be more preferable for the individual. We are also aware that slow reductions in the community don't necessarily have the good outcomes we would want. However, the reality is that we do not have specific evidence for all the treatment options available for the person we are trying to help. That person is unique and we can only be guided by general principles and population based evidence and we have to use our clinical skill to tailor treatment to that person and their circumstances.

Questions to ask

Here are some questions which you may well have asked already but need to be explored:

- What exactly does the patient want and what is the timescale?
- How fixed or flexible is this?
- Why does he want to stop completely and does he have to do this before starting training?
- Why is he sometimes still using crack and benzodiazepines, and is he really being honest about how much and how often he is using?
- What was his previous experience of what worked and didn't and why?
- What support does he have?
- Are circumstances at home likely to cause relapse?
- What does his keyworker think? If he doesn't have one why not!
- Who would provide funding if he opts for residential treatment and how is this accessed?
- Are there medical or psychiatric problems which could make community detoxification more risky?
- Is the patient aware of risk of relapse to drug and/or alcohol use and the dangers of this to his health?

The treatment options will depend on the answers to these questions and a collaborative approach to making a plan with the patient and the keyworker is essential. It is important not only to plan the detoxification but also the aftercare – what measures can you jointly put in place to prevent relapse, and to reduce the risks of relapse should it occur?

The options

If a rapid detoxification is agreed on then a specialist residential treatment unit is the best option if funding is available. Even this may take a significant length of time; in our unit we work on an average reduction of about 3ml of methadone daily. What actually happens is that people reduce from larger doses such as 120ml by up to 5-10ml daily initially, and then reduce the reduction rate as they come down. A lot of people get increasing problems with even small reductions of 1-2ml when under 15-20mls. This may be because the reductions are a larger proportion of the total dose or due to changes at the opiate receptor level. Withdrawal symptoms do persist after finishing methadone and can still be significant and require supportive treatment for one-to-two weeks. Therefore coming off 120mls methadone could take up to six weeks even in a residential unit. Sometimes people will reduce to a certain amount, go out for a couple of weeks on a stable dose and then come back in to finish the detox.

Another option is a quasi residential detox/ rehab centre where people are not resident at the unit but get housed locally or in their own home and travel in daily. They may be restricted in terms of how much methadone they can be accepted on and there may be other conditions that need to be met.

The final option is a detox in the community with an agreed reduction regime. Clearly this depends on the timescale requested and confidence of both you and the patient. It is very important to give reassurance that reduction can be slowed or stopped or even reversed if needed. The process in the community is likely to be a lot slower than as an inpatient. There is no set reduction rate: it depends on the motivation and tolerance to withdrawal effects. It is usually easier to reduce by larger amounts when the overall dose is high. For example you may agree together to reduce initially by 5ml a week, and this will take more than twenty-four weeks. Reducing 10ml a week will take more than twelve weeks. Initial reductions can be higher and then later reductions can be lower as discussed above.

I don't recommend conversion to buprenorphine at a lower methadone dose. I am aware that there is a feeling around that it is easier to come off Subutex than methadone but in my experience this just means people have to suffer two sets of withdrawal symptoms: once on change over and then when they are stopping buprenorphine. It also means extra time and input for all parties, and potential

...continued overleaf

destabilisation of the whole process at the change over period.

Supportive help during detoxification

The choice, amount and administration of supportive medication for opiate detoxification does depend on the setting which ranges from residential with nursing staff permanently on site twenty-four hours-a-day to detox in the community with no staff. There also exist a variety of options in between. For a community detoxification, if needed, I would use (if not contraindicated) Buscopan, buccal prochlorperazine, loperamide, paracetamol and ibuprofen. I do use a hypnotic for up to four weeks if really needed, but I would start it when the patient is under 15ml of methadone to avoid developing another dependency and I would try a non benzodiazepine Z hypnotic if possible. These do not show up in urine screens so any benzodiazepines present would be an indication of illicit use. I would also give quinine sulphate for leg cramps as we have found this useful although the effect is not supposed to start immediately. Though recommended by National Institute of Clinical Excellence[1], I haven't found lofexidine very helpful even in an inpatient setting where there is a lot of monitoring available. People sometimes ask for benzodiazepines to help with their withdrawal symptoms. Personally I don't usually give any except in exceptional circumstances, as it can make things worse in the longer term for obvious reasons, but it depends on your experience and relationship with the patient.

See him regularly if reducing regularly – I suggest every 2 weeks – and make sure he has the next appointment before he leaves the surgery. I used to make it there and then and give the patient a card with it written on. Make sure he has a keyworker available who will see him regularly, if needed between your appointments.

Continue to see your patient regularly and watch out for relapse onto heroin and warn him about loss of tolerance. Watch for benzodiazepine use and alcohol use starting again. Encourage honesty. He is not under compulsion to detox and the therapeutic relationship should not be confrontational, even though his experience in the past may have been different. After all, it's his detox! There should be a low threshold for being able to get back into treatment and restarting opiate substitution if he needs to.

Aftercare

Therapeutic engagement should continue after the detoxification is complete. Self help groups, for example Narcotics Anonymous or SMART Recovery, can be really important for some people and particularly at this stage.

Once detoxified, if all goes well he may benefit from naltrexone, ideally supervised by another person such as a partner or carer, or possibly a pharmacist. This should be discussed with him at the outset when sorting out a treatment plan.

Conclusion:

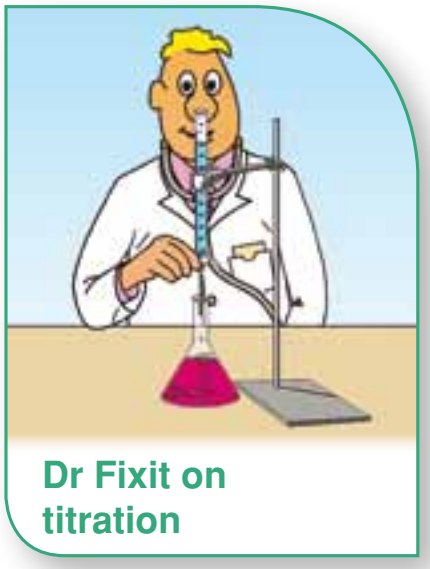
When we are trying to help people with drug and alcohol problems, I believe the two most important factors are:

1. Knowing what you are doing and being keen to seek help and advice when you need it, and
2. Building a therapeutic relationship based on mutual respect and empathy for the person.

I call this *competent compassion* and believe it encapsulates what we should all be doing in this most demanding but rewarding field of substance misuse.

1 National Institute for Clinical Excellence (2007) Drug misuse: opioid detoxification Clinical guideline CG32

Dr Fixit Chris Ford outlines the different approaches to titration for methadone and buprenorphine. Ed.



Dr Fixit on titration

Dear Dr Fixit

I feel confident about starting methadone as I have now done it many times but am very uncertain about starting buprenorphine or Suboxone and would value your help. I started Jack aged 28 years, on buprenorphine last week and after taking 5 days to get him to 8mg he had had enough and asked to be changed to methadone. I really feel I have failed him.

Answer provided by Chris Ford GP Lonsdale Medical Practice and Clinical Director, SMMGP

Thanks for your question, which is not an uncommon one. Don't feel you are a failure, you have kept Jack in treatment and may be able to transfer him back to buprenorphine in the future if this is appropriate. As I am sure you do, before starting either medication always confirm opioid dependence by history, examination and toxicology. As you have discovered, the induction of methadone and buprenorphine are very different. When starting methadone, we start low and increase slowly. The purpose of titration on methadone is to establish the patient, in a safe manner and as quickly as possible, on a dose of methadone that prevents opioid withdrawal, reduces the need to take additional illicit opioids and keeps side effects to a minimum. Insufficient dosing heightens the risk of additional illicit drug use and hence diminishes treatment effectiveness and increases the risk of accidental overdose. There is a need to start at a low dose and titrate up until an optimal dose is reached, but too high an initial dose and/or too rapid an increase also adds to overdose risk in this period because of the accumulative effect before steady state is reached. This titration process and the reason for being cautious must be explained to the patient. The starting dose of methadone should be between 10 and 30mg daily, depending on the amount of heroin or other opiates being used, and titrated upwards to optimal levels, usually between 60 and 120mg. As over 20% of all methadone deaths in treatment take place within two weeks of commencement of prescribing (most occurring during sleep) there is a need for caution at titration. The risk of overdose is increased by low opioid tolerance, too high an initial dose, too rapid increases and concurrent use of other drugs, particularly alcohol, benzodiazepines and antidepressants.

Starting buprenorphine and Suboxone® is very different. The purpose of induction is the same, that is, to establish Jack as quickly as possible and in a safe manner on a dose of buprenorphine that prevents

opioid withdrawal, reduces the need to take additional illicit opioids and keeps side effects to a minimum. But the rest is very different. As with methadone, we start buprenorphine on a low dose but unlike methadone, Jack must take it at least 8-12 hours after his last dose of heroin (and 24-36 hours after methadone) when he has experienced some withdrawal, to avoid precipitated withdrawal (see below). This is only necessary for the first dose. You can safely increase subsequent doses rapidly over the course of the next few days, until a stabilising dose (usually between 12 and 32mg) is reached. Doses above 12mg block the effect of heroin and other opiates if used on top.

Jack should experience minimal complications, although restlessness, insomnia, headache, diarrhoea and other mild opioid withdrawal-like symptoms in the first 1–3 days when titrating on to buprenorphine from heroin or low-dose methadone (30mg or below) can occur. Lofexidine may be helpful with these unpleasant side effects. He will reach steady state of buprenorphine in the blood concentration levels after about 5–8 days. Give him advice about sleep hygiene.

You only need to worry about precipitated withdrawal with the first dose and the longer after his last opiate use Jack takes his first dose, the lower this risk will be. To achieve this, I usually give the first dose of buprenorphine to the patient to take home, to be taken at an appropriate time of their choosing when the onset of withdrawal occurs. We usually start between 2mg and 8mg, but I have now used starting doses of up to 16mg, as these are safe. After that, try and see Jack daily and increase the buprenorphine dose on subsequent days, or later the same day, according to his clinical response. Continue to review Jack frequently. Supervision of his doses through induction and until he is stable can be helpful.

Provide a full explanation of the drug and what could happen to him and his partner/carer if he has one and ensure that they understand that most people take several days to stabilise on their medication, particularly if transferring from methadone (where stabilisation can take 1–2 weeks). Precipitated withdrawal should also be explained.

If Jack does decide to try buprenorphine again, work with him to reduce his methadone dose as much as possible, usually to 30mg or less. If you did want to try transfer from a dose higher than 30mg methadone, delay his first dose as long as possible and until Jack displays clear signs of withdrawal (between 24 and 96 hours) after the last methadone dose. You can give him symptomatic medication, such as lofexidine. Start with an initial dose of 4mg of buprenorphine, and review him 2–3 hours later. If he has no precipitated withdrawal or worsening of withdrawal, then give an additional 2–4mg of buprenorphine.

N.B. If a patient is on more than 60mg of methadone and wants to change to buprenorphine, then they should be referred to a local specialist who has experience of managing this transfer.

What is precipitated withdrawal?

This form of opiate withdrawal can occur in someone commencing buprenorphine who has recently used heroin or other opiates (less than 8 hours previously for heroin and as much as 36 hours for methadone). It is caused by the high affinity of buprenorphine for displacing other opioids (e.g. methadone and heroin) from opioid receptors, but having less opioid activity (partial agonist). This rapid reduction in opioid effects can be experienced as precipitated withdrawal, typically occurring within 1–3 hours of the first buprenorphine dose, peaking in severity over the first 3–6 hours, and then generally subsiding. If it occurs, reassure the patient and carer, confirm that it is unpleasant but not dangerous and that it will pass, and offer symptomatic treatment if withdrawal symptoms are severe. Do not prescribe more buprenorphine until the opiate withdrawal symptoms have settled.

In eleven years of using buprenorphine I have had two patients who have experienced precipitated withdrawal. My first was Bob who had not used heroin for twelve hours but had no withdrawal symptoms. He said it was unpleasant but less severe than 'cold turkey' from heroin, he settled well with diazepam and has now been drug free for three years, following three years of buprenorphine maintenance of 16mg. My other patient, Angela, admits she took her first dose of buprenorphine six hours after taking methadone so took full responsibility for the difficult three days she had with headache, diarrhoea and insomnia, but she stuck in there and is now stable on 12mg maintenance.

Good luck with Jack. It's nice having at least one other drug we can use safely as methadone isn't prefect for everyone.

RCGP Certificate in Harm Reduction, Health and Wellbeing for Substance Users – an update

A training day for trainers for the new RCGP Certificate in Harm Reduction, Health and Wellbeing was held recently and the certificate will now be finalised based on feedback from our group of high-calibre attendees, for full launch towards the end of March 2011.

The idea to develop this certificate arose a while ago from the now seemingly distant Harm Reduction Action Plan and was finessed over time to include health and wellbeing as a natural progression towards whole person recovery. It is therefore an exciting time to be launching this certificate which fits in perfectly with the current drug strategy.

It is designed as an introduction to consider the health, wellbeing and harm reduction of patients who use drugs and / or alcohol for front line practitioners who see these patients regularly to be able to recognise and help them with health; as well as a good refresher certificate for past Part 1 completers to update them on the recovery focused agenda. It consists of an emodule and a face-to-face training day.

For more information contact Marianne Thompson, RCGP SMU on mthompson@rcgp.org.uk

Problematic use of over-the-counter (OTC) medication, benzodiazepines and other prescribed medications – how do we manage these increasing problems?

Harrogate Majestic Hotel, Wednesday, 11th May 2011

In response to demand, SMMGP is delighted to announce a training day to look at the issues involved in drugs that are not necessarily termed illicit. The new Drug Strategy rightfully identifies the use of OTC medications and some prescription drugs as increasingly problematic, and calls for services to develop to meet the needs of the group of patients who can develop serious problems with these medications. This day will look at what we know, what we don't know and what we can offer.

Cost for SMMGP members is £180 and for all other delegates £190. A flyer is available on our website, or if you are interested in attending please contact Sarah Pengelly sarah.mpa@dial.pipex.com

COURSES AND EVENTS

Problematic use of over-the-counter (OTC) medication, benzodiazepines and other prescribed medications – how do we manage these increasing problems?
Venue: **Harrogate Majestic Hotel,**
Date: **Wednesday, 11th May 2011**
Contact Sarah Pengelly **sarah.mpa@dial.pipex.com**

RCGP 16th National Conference:
Working with Drug & Alcohol Users in Primary Care - "The Public Health Agenda: Making Patient Centred Care the Imperative"
Date: **Thursday 12 - Friday 13 May 2011**
Venue: **Harrogate International Centre**
For more information visit
http://www.smmgp.org.uk/download/rcgpconference/rcgp16/rcgp16h00.pdf

Parental Substance Misuse Conference:
Children Affected by Parental Substance Misuse - Getting it Right for Every Family
Date: **Tuesday 8 March 2011, 9am-5.30pm**
Venue: **Edinburgh**
Contact **E-mail: info@medineo.org**

7th National Conference on Sexual Health and Contraception in General Practice:
Practice Makes Perfect - Prevention, Diagnosis and Treatment
Date: **Friday 11 March 2011, 9.00am-4.00pm**
Venue: **76 Portland Place, London W1B 1NT**
More information from **www.rcgp.org.uk/courses**
E-mail: **jsmith@rcgp.org.uk**

Introductory Certificate in Sexual Health (ICSH)
Date: **Wednesday 23 March 2011**
Venue: **Palace Hotel, Manchester M60 7HA**
For more information visit
http://www.smmgp.org.uk/download/events/events005.pdf

Alcohol Related Disorders: Towards an Integrated Care Pathway
supported by the Royal College of Psychiatrists and NICE
Tuesday 10 May 2011
Venue: **Royal College of Physicians**
Location: **London**
For more details
http://events.rcplondon.ac.uk/details.aspx?e=2207

Naloxone Saves Lives Conference
Date: **Thursday 19 May 2011**
Venue: **Swansea**
E-mail: mjones@swanseadp.org.uk

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